

health services subject to the limitation for each year during which the limitation is phased out are as follows:

| Calendar year                          | Recognized incurred expenses | Patient pays | Medicare pays |
|--|------------------------------|--------------|---------------|
| CY 2009 and prior calendar years ..... | 62.50%                       | 50%          | 50%           |
| CYs 2010 and 2011 ..                   | 68.75%                       | 45%          | 55%           |
| CY 2012 .....                          | 75.00%                       | 40%          | 60%           |
| CY 2013 .....                          | 81.25%                       | 35%          | 65%           |
| CY 2014 .....                          | 100.00%                      | 20%          | 80%           |

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,

(3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.

(4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

[63 FR 20129, Apr. 23, 1998, as amended at 73 FR 69934, Nov. 19, 2008; 74 FR 62005, Nov. 25, 2009]

#### §410.160 Part B annual deductible.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, incurred expenses (as defined in §410.152) are subject to, and count toward meeting the annual deductible.

(b) *Exceptions.* Expenses incurred for the following services are not subject to the Part B annual deductible and do not count toward meeting that deductible:

(1) Home health services.

(2) Pneumococcal vaccines and their administration.

(3) Federally qualified health center services.

(4) ASC facility services furnished before July 1987 and physician services furnished before April 1988 that met the requirements for payment of 100 percent of the reasonable charges.

(5) Screening mammography services as described in §410.34 (c) and (d).

(6) Screening pelvic examinations as described in §410.56.

(7) Beginning January 1, 2007, colorectal cancer screening tests as described in §410.37.

(8) Beginning January 1, 2007, ultrasound screening for abdominal aortic aneurysms described in §410.19.

(9) Beginning January 1, 2009, initial preventive physical examinations as described in §410.16.

(c) *Application of the Part B annual deductible.* (1) Before payment is made under §410.152, an individual's incurred expenses for the calendar year are reduced by the Part B annual deductible.

(2) The Part B annual deductible is applied to incurred expenses in the order in which claims for those expenses are processed by the Medicare program.

(3) Only one Part B annual deductible may be imposed for any calendar year and it may be met by any combination of expenses incurred in that year.

(d) *Special rule for services reimbursable on a formula basis.* (1) In applying the formula that takes into account reasonable costs, customary charges, and customary (insofar as reasonable) charges, and is used to determine payment for services furnished by a provider that is not a nominal charge provider, the Medicare intermediary takes the following steps:

(i) Reduces the customary charges for the services by an amount equal to any unmet portion of the deductible for the calendar year, in accordance with paragraph (b) of this section. (The amount of this reduction is considered to be the amount of the deductible that is met on the basis of the services to which it is applied.)

(ii) Determines 20 percent of any remaining portion of the customary (insofar as reasonable) charge.

(iii) Determines the lesser of the reasonable cost of the services and the customary charges for the services.

(iv) Reduces the amount determined under paragraph (c)(1)(iii) of this section by the sum of the reduction made under paragraph (c)(1)(i) of this section and the amount determined under paragraph (c)(1)(ii) of this section.

(v) Reduces the reasonable cost of the services by the amount of the reduction made under paragraph (c)(1)(i) of this section and multiplies the result by 80 percent.

(2) In accordance with §410.152(b)(1), the amount payable is the amount determined under paragraph (c)(1)(iv) of this section, or the amount determined under paragraph (c)(1)(v) of this section, whichever is less.

(e) *Special rule for services of an independent rural health clinic.* Application of the Part B annual deductible to rural health clinic services is in accordance with §405.2425(b)(2) of this chapter.

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 2006, and for all succeeding years, the annual deductible is the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees age 65 and over, rounded to the nearest dollar.

(2) For 2005, the deductible is \$110.

(3) From 1991 through 2004, the deductible was \$100.

(4) From 1982 through 1990, the deductible was \$75.

(5) From 1973 through 1981, the deductible was \$60.

(6) From 1966 through 1972, the deductible was \$50.

(g) *Carryover of Part B annual deductible.* For calendar years before 1982, the Part B annual deductible was reduced by the amount of expenses incurred during the last quarter of the preceding year that was applied to meet the deductible for that preceding year. *Example:* If \$20 of expenses incurred in November 1980 was used to meet the 1980 deductible, the 1981 deductible was reduced to \$40 (\$60–\$20).

(h) *Examples of application of the annual deductible.* (1) Mr. A submitted claims for the following expenses incurred during 1982: \$20 for services furnished in March by physician X; \$30 for services furnished in April by physician Y; \$50 for services furnished in June by physician Z, for a total of \$100. The carrier determined that the charges as submitted were the reasonable charges. The first \$75 of expenses for which claims were processed is applied to meet the \$75 deductible for that year.

Medicare Part B pays 80 percent of the remaining \$25, or \$20.

(2) Mr. B submitted a claim that included a \$25 charge by a doctor for an examination to prescribe a hearing aid and an \$80 charge for office surgery. This was the first claim relating to Mr. B's medical expenses processed in the calendar year. The carrier disallowed the \$25 charge because the type of examination is not covered by Medicare. The carrier reduced the \$80 surgery charge to a reasonable charge of \$40. Only the \$40 reasonable charge for covered services will count toward meeting Mr. B's deductible. Since the remainder of the surgery charge constitutes and excess over the reasonable charge, it cannot be applied to satisfy Mr. B's deductible.

(3) Mr. C became entitled to Medicare Part B benefits on July 1, 1982. He incurred expenses of \$200 in July, August, and September. The carrier determined that the charges as submitted were reasonable. Even though Mr. C was entitled to benefits for only half the year, he must meet the full \$75 deductible. Thus, \$75 of this expense constitutes Mr. C's deductible. Medicare would pay \$100, which is 80 percent of the remaining \$125.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8842 and 8852, Mar. 1, 1991; 57 FR 24981, June 12, 1992; 62 FR 59101, Oct. 31, 1997; 69 FR 66423, Nov. 15, 2004; 71 FR 69785, Dec. 1, 2006; 73 FR 69934, Nov. 19, 2008]

#### §410.161 Part B blood deductible.

(a) *General rules.* (1) As used in this section, *packed red cells* means the red blood cells that remain after plasma is separated from whole blood.

(2) A unit of packed red cells is treated as the equivalent of a pint of whole blood, which in this section is referred to as a unit of whole blood.

(3) Medicare does not pay for the first 3 units of whole blood or units of packed red cells that are furnished under Part A or Part B in a calendar year. The Part B blood deductible is reduced to the extent that a blood deductible has been applied under Part A.

(4) The blood deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin and serum albumin, or